STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS ALZHEIMER'S SPECIAL CARE CENTER	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00124832. Complaint IN00124832 - Substantiated. State Residential finding related to allegations are cited at R0036 and R0349. Survey dates: May 8th and 9th, 2013. Facility number: 012706 Provider number: 012706 AIM number: N/A Survey team: Susan Worsham, RN-TC Cheryl Mabry, RN Diana McDonald, RN Census bed type: Residential: 38 Total: 38 Census payor type: Other: 38 Total: 38 Sample: 06 These state findings are cited in	R000000	**REQUEST FOR PAPER COMPLIANCE: Autumn Hills Alzheimer's Special Care Center respectfully requests consideration for paper compliance for survey event id UZIY11 which includes deficiency number R0036 and R0349. Thank you for your consideration in this important matter. This plan of correction is to serve as Autumn Hills Alzheimer's Special Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Autumn Hills Alzheimer's Special Care Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2. Quality Review completed on May 16, 2013; by Kimberly Perigo, RN.			

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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and Interview, the facility failed to immediately inform a resident's physician and legal representative after a fall which required medical treatment. (Resident #A) Findings include: Resident #A's clinical records were reviewed on May 09, 2013 at 2:02 p.m. A current mobility form indicated Resident #A was unsteady on his feet without his walker and the provider escorts the resident to all activities and to and from the dining room. To never get in between the resident and his walker, as he is very protective of it. Nurses notes dated 2/19/13 at 7:25 p.m., indicated "...resident was	R000036	**R036 410 IAC 16.2-5-1.2(k)(1-2) Resident's Rights-Deficiency** It is the practice of Autumn Hills Alzheimer's Special Care Center to immediately inform a resident's physician and legal representative after a fall which requires medical treatment. I. RN has been re-educated on the facility's policy regarding informing the resident's physician and legal representative after a fall which requires medical treatment. II. The facility realizes other residents have the potential to be affected. This has been addressed by the systems described below.	06/08/2013

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	hurrying into room #36 with his walker got caught on the doorway and had to be assisted into a wheelchair." Interview with CNA #2 on May 09, 2013 at 10:00 a.m., indicated that another CNA, who has since moved out of state, informed her (CNA #2) that she (other CNA) was walking behind Resident #A when he attempted to go into his room and hit the door with his walker, causing him to lose balance. She (other CNA) was unable to hold him up and lowered him to the floor and called for help. The nurses notes do no reflect any assessment by the nurse other than placing an ice pack on the resident's right ankle and giving resident some Tylenol. She did indicate that Resident #A appeared to be protective of his right lower leg. There is no documentation to indicate the Nurse called Resident #A's family or the physician, after the fall. The next notation on the chart was at 6 a.m. 2/20/13, by the morning nurse. There was no more documentation until the second shift nurse came on duty at 2 p.m. Record review of those notes indicated that Resident's wife did state that he will not tolerate or allow an X-ray. However, after		III. As noted in the survey report, the facility has a policy regarding immediately informing a resident's physician and legal representative after a fall which requires medical treatment. Licensed facility personnel have been re-educated on this policy including the importance of immediately notifying a resident's physician and legal representative after a fall which requires medical treatment. Additional systemic changes are being implemented through our quality improvement program as indicated below. IV. The HSD or her designee is completing quality improvement audits of documentation of the immediate notification of physicians and legal representatives after a fall which requires medical treatment. The audits will be performed for 100% of residents who experience a fall for 60 days, then 50% of residents who experience a fall for 6 months. Results of all audits will be reported monthly to the facility's Administrator and designated QI team for additional recommendations if necessary. COMPLETION DATE: 6/8/13	

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	continued complaints of discomfort, the physician ordered an X-ray, which was done on 2/21/13 at 11:00 a.m. Review of X-ray results dated 2/21/13 indicated a right hip fracture diagnosis. Resident #A was then transferred to a local acute care hospital for a direct admit to an Orthopedic Surgeon. Review of facility's Fall Assessment policy, provided by the DON, indicated when a resident falls, the staff are to follow the procedure outlined in the Fall Management Policy and notify the physician and family, as well as place the resident on alert charting and on the 24 hour report sheet. Interview with the DON 5/9/13 at 11:00 a.m., indicated those forms could not be found. Documentation to indicate Resident A's family and physician had immediately been notified after the fall on 2/19/13, was not provided. This Residential finding relates to Complaint IN00124832.			

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R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation in the clinical record was complete and accurate for 1 of 6 residents. (Resident #A) Findings include: The clinical record of Resident # A was reviewed on 5/8/13 at 2:02 p.m. The nurses notes dated 2/19/13 at 7:25 p.m., indicated Resident #A was provided staff's assistance to go into his room, caught his walker on the door frame, stumbled, and had to be assisted into a wheelchair. The clinical record lacked documentation which indicated a fall. Interview with CNA #2 on 5/9/10:50 a.m., indicated that the CNA in the report no longer worked there, but had stated to her (CNA #2) that she (other CNA) was walking behind the	R000349	**R349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance** It is the practice of Autumn Hills Alzheimer's Special Care Center to ensure documentation in the clinical record is complete, accurately documented, readily accessible and systematically organized. I. RN has been re-educated on the importance of documenting in the clinical record a complete and accurate accounting of nursing services including falls assessments per the facility policy on Falls Management. II. The facility realizes other residents have the potential to be affected. This has been	06/08/2013

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	resident when his walker hit the door frame, the resident stumbled back, and she eased him to the floor. She (other CNA) also indicated that the resident was much larger than the CNA, so the CNA called out for help and did not try to move the resident. The nurses notes do no reflect any assessment by the nurse other than placing an ice pack on the resident's right ankle and giving resident some Tylenol. She did indicate that Resident #A appeared to be protective of his right lower leg. The next nurse's documentation was noted to be on 2/20/13 at 6:00 a.m. With the next documentation was indicated on 2/20/13 at 2:00 p.m. Review of facility's Fall Assessment policy, provided by the DON, indicated when a resident falls, the staff are to follow the procedure outlined in the Fall Management Policy and notify the physician and family, as well as place the resident on alert charting and on the 24 hour report sheet. Interview with the DON on 5/9/13, at 10:55 a.m., indicated that a resident fall assessment is done when a resident falls, but one was not done		addressed by the systems described below. III. Licensed nurses have been re-educated regarding the importance of ensuring complete and accurate documentation that is readily accessible and systematically organized according to the facility Falls Management policy. Additional systemic changes are being implemented through an audit program as indicated below. IV. The HSD or her designee is completing audits of Falls Management documentation to ensure that the medical record is a complete and accurate reflection of the provision of nursing services following a fall. A random sample of licensed nurses will be observed weekly for 4 weeks, then every other week for 4 weeks, then monthly for 6 months. Results of all audits will be reported to the facility Administrator and designated QI team monthly for additional recommendations if necessary. COMPLETION DATE: 6/8/13	

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	on this resident. On 5/9/13 at 11:45 a.m., interview with the DON indicated that after she looked in the chart, she indicated that there was no documentation for the fall or a follow up assessment sheet, per the facility's policy and procedure. This Residential finding relates to Complaint IN00124832.			